

GOVERNMENT OF THE DISTRICT OF COLUMBIA
BUREAU OF MOTOR VEHICLE SERVICES
301 C STREET, N.W.
WASHINGTON, D.C. 20001

DIABETIC MEDICAL QUESTIONNAIRE

THE FOLLOWING MUST BE ANSWERED BY A LICENSED PHYSICIAN:

NAME OF APPLICANT _____ AGE _____ SEX _____

ADDRESS _____

AGE AT ONSET OF DIABETES _____

1. Statements regarding physical and mental impairments

2. Has he/she ever had a diabetic coma _____, insulin coma _____ or hypoglycemic reaction?

_____ How often does this occur and when was the last time?

3. Does he/she take insulin or oral hypoglycemic agents or a combination of both? _____ Describe the type of medication taken and dosage.

4. What diet does he/she follow: CHO _____ P _____ F _____ Calories _____

5. Is this person a reliable and responsible diabetic? _____ If he/she is not, explain _____

6. Do you consider this person physically qualified to operate a motor vehicle safely? _____ If he/she is not, please qualify. _____

7. Do you feel that any special conditions should be imposed in connection with the issuance or renewal of an operator's permit to this person for a four-year period? if yes, explain _____

PHYSICIAN'S SIGNATURE

DATE OF REPORT

ADDRESS

TELEPHONE NUMBER

PERMISSION TO RELEASE THIS INFORMATION

I hereby authorize my physician to release the above information to the District of Columbia's Bureau of Motor Vehicle Services. However, this material is confidential and cannot be released to other agencies, public or private, without my express written permission.

Signature of Applicant _____ Date _____